HEALTH AND COMMUNITY SUPPORTS CONTRACT

CONTRACT INTERPRETATION BULLETIN for CY 2000 CONTRACT

CIB #2000-3: Grandfathers – Per Member Per Month

June 2, 2000

CONTRACT SECTIONS AFFECTED

HCS Sec. XVII. CMO Specific Contract Terms

STATEMENT OF POLICY

The statutes provide that anyone in the Family Care target groups who 1) is financially eligible for Family Care, and 2) has a condition requiring long-term care that is expected to last at least 90 days or result in death within 12 months after the date of application and, on the date that the Family Care benefit becomes available in his or her county of residence, has been receiving, for at least 60 days, under a written plan of care, long term care services that were funded by COP, the Alzheimer's Family Care Giver Support Program, Community Aids, or county funding is eligible and entitled to Family Care. If such a person fails the Long Term Care Functional Screen at both the comprehensive and intermediate level, he or she will still be "grandfathered" into Family Care.

The DHFS Executive team recognizes that the intent of the grandfather provision was to ensure that no one receiving long term care services will receive less care as a result of the change to Family Care in his or her county of residence. Since the majority of individuals with long term care needs are expected to qualify at least the intermediate level, the number of grandfathered individuals and their needs are expected to be limited even though they qualify to receive the Family Care benefit. Because the number grandfathered into Family Care is expected to be small, it is not feasible to develop a single capitated rate appropriate for all potential grandfathers.

AUTHORITY FOR CONTRACT PROVISIONS

The HCS contract Section XVII states the Department will develop a mechanism for payment to the CMO for individuals grandfathered into Family Care. The Contract provision was intended to allow the Department to consider how to establish standards for those individuals entering Family Care pursuant to the Grandfather provision as set forth in Sec. 46.286(1)(a)2. Wis. Stats.

CONTRACT INTERPRETATION

For members who are functionally eligible through the grandfathering provision, and not functionally eligible at the comprehensive or intermediate level of care, the Department has determined rates and service specifications in the LTC benefit package as follows:

1. Counties shall identify potential grandfathered participants and current costs as of May 1, 2000, as well as indicate which participants are still receiving services on July 1, 2000 (The CMO and RC pilots in Fond du Lac, Portage, La Crosse and Milwaukee Counties have already been asked to send this information to the Department). Before enrolling any of these individuals, they must be screened for functional eligibility using the COP functional screen and the *Long Term Care Functional Eligibility Screen*. Only people who are not otherwise functionally eligible can be grandfathered into Family Care.

2. Financial eligibility for Family Care is the same for grandfathered individuals as for individuals who qualify functionally at the intermediate or comprehensive level. Individuals determined to be functionally eligible under the grandfathering provision shall be referred to Economic Support for determination of financial eligibility. Persons eligible for Family Care under the grandfather provisions are subject to all Family Care cost-sharing and financial eligibility reporting requirements.

3. Persons eligible for Family Care under this grandfather provision are entitled to all the benefits and rights of membership in the CMO and all contract provisions apply equally to them.

4. The CMO shall be reimbursed the actual cost of the existing care plan for grandfathered enrollees at the time they become eligible for Family Care (the cost reported by the county as described in (1) above). Case management for grandfathered individuals is expected to be minimal. The CMO shall receive an additional $50.00 per month for case management for each grandfathered enrollee. The total will be paid to the CMO on a prospective basis.

5. The CMO shall be required to develop a plan of care and provide those services required to meet the enrollee's needs as described in the care plan.

6. If the care needs of an individual increase, the CMO will need to request that the individual be rescreened to determine whether additional needs meet the intermediate level of care.